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Public Health
Seattle & King County

Health Advisory – CDC Recommends Increased Vigilance for Acute Flaccid Myelitis, 29 July 2016

Action requested:

- **Be aware that 21 confirmed cases of acute flaccid myelitis (AFM) have been reported to CDC during January 1–June 30, 2016 among persons 6 months to 64 years of age (median 7 years).**
- **Consider AFM in patients presenting with onset of acute focal limb weakness AND a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter* AND spanning one or more spinal segments OR cerebrospinal fluid (CSF) showing pleocytosis (white blood cell count >5 cells/mm3)**
- **Collect specimens from patients suspected of having AFM as early as possible in the course of illness (preferably on the day of onset of limb weakness) including:**
  - **CSF**
  - **Whole blood**
  - **Serum**
  - **Peripheral blood mononuclear cells (PBMC)**
  - **Stool**
  - **An NP aspirate, NP wash, or NP swab (with lower respiratory specimen if indicated)**
  - **An oropharyngeal swab**

  Collection of specimens as close to the onset of illness as possible has the best chance to yield a diagnosis.
- **Report confirmed or suspected cases of AFM promptly to Public Health at (206) 296-4774. Public Health will provide guidance on laboratory testing of specimens for enteroviruses, West Nile virus, and other infectious etiologies known to be associated with AFM.**
- **Please complete the patient summary form found here when reporting patients to Public Health:** (http://www.cdc.gov/acute-flaccid-myelitis/hcp/data.html).

Background: From January 1, 2016 through June 30, 2016, CDC received 36 reports of suspected acute flaccid myelitis (AFM) in persons from 20 U.S. states; a total of 21 met the Council of State and Territorial Epidemiologist (CSTE) case definition for a confirmed case of AFM and three were classified as probable. During the same period in 2015, CDC received only eight reports of suspected AFM, of which five were classified as confirmed. Dates of onset for confirmed cases ranged from December 1, 2015 through June 18, 2016; 48% (10/21) had onset of limb weakness after May 1, 2016. Because of the reports of a possible epidemiological association of EVD-68 and AFM in 2014, cerebrospinal fluid (CSF) specimens available from 86% (18/21) of confirmed cases were tested at CDC; all specimens were negative for enterovirus at CDC. Pleocytosis was present in 81% (17/21) of confirmed AFM cases with a median of 50/mm3 (range, 6-758/mm3).

Resources

- For more information on AFM: http://www.cdc.gov/acute-flaccid-myelitis/index.html
- For guidance on clinical management of patients with AFM: http://www.cdc.gov/acute-flaccid-myelitis/downloads/acute-flaccid-myelitis.pdf

Instructions for Completing the AFM Patient Summary Form

GENERAL. Clinicians should report all patients who meet the case definition (as specified on page 4) for AFM to their state or local health department using this *Patient Summary Form*.

a. Clinicians should report patients who meet the case definition regardless of any laboratory results.
b. This form should be completed by, or in conjunction with, a clinician who provided care to the patient during the neurologic illness.
c. So that cases can be monitored in as real time as possible, this form should be submitted to the state or local health department as soon as possible after case identification.

CDC requests that state health departments also submit the *Patient Summary Form* to CDC to help monitor these cases at the national level. A form that is largely complete but has some information pending (e.g., hospital or health department laboratory results) or under investigation (e.g., polio vaccination history) should still be submitted as soon as possible, and the pending results can then be provided to CDC when they become available.

Demographics

1. **TODAY'S DATE.** Date that clinician is initiating completing the patient summary form.
2. **STATE ASSIGNED ID**. Alpha/numeric
3. **SEX**. Indicated whether the case-patient is male or female.
4. **DATE OF BIRTH**. Case-patient birth date.
5. **RESIDENCE.** State in which case-patient resides.
6. **COUNTY.** County in which case-patient resides.
7. **RACE.** Self-reported race of case-patient; more than one option may be reported.
8. **ETHNICITY.** Self-reported ethnicity of case-patient.
9. **DATE OF ONSET OF LIMB WEAKNESS.** Limb weakness onset date of case-patients.
10. **HOSPITALIZED?** Was case-patient hospitalized?
11. **DATE HOSPITALIZED.** Date case-patient FIRST hospitalized.
12. **DATE DISCHARGED.** Date case-patient discharged from LAST hospital (indicate if still hospitalized).
13. **DIED?** Did case-patient die from this illness?
14. **DATE OF DEATH.** Case-patient's date of death.

Signs/symptoms/condition at ANY time during the illness

If the answer to a question is truly UNKNOWN or no information is recorded in the medical record (NOT RECORDED or NR) then check the UNK/NR box, otherwise, leave answer blank.

15. **WHICH LIMBS HAVE BEEN ACUTELY WEAK?** Specify any/all limbs (arms and or legs) for which there was noted acute onset of focal weakness.
16. **DATE OF NEUROLOGIC EXAM.** The neurologic examination date recorded at most severe weakness to that point.

17. **REFLEXES IN THE AFFECTED LIMB(S).** Numeric value assigned to reflexes in affected limb(s) recorded at the most severe weakness to that point.
18. **SENSORY LOSS/NUMBNESS?** Has case-patient experienced any sensory loss or numbness in the affected limb(s) at any time during the illness?
19. **BURNING PAIN?** Has case-patient experienced any burning pain in the affected limb(s) at any time during the illness?
20. **SENSORY LEVEL ON THE TORSO?** Has case-patient experienced reduced sensation below a certain level below the torso at any time during the illness?
21. **CRANIAL NERVE FEATURES.** Did case-patient have any cranial nerve features? If YES, indicate the type experienced by the case-patient.
22. **BOWEL OR BLADDER INCONTINENCE?** Has case-patient experienced at any time during the illness bowel or bladder incontinence?
23. **CHANGE IN MENTAL STATUS?** Has case-patient experienced at any time during the illness a change in mental status?
24. **SEIZURES?** Has case-patient experienced any seizures at any time during the illness?
25. **RECEIPT OF POSITIVE PRESSURE VENTILATION?** Has case-patient received positive pressure ventilation, including invasive or non-invasive ventilation and BiPAP or CPAP?

Other patient information

26. **RESPIRATORY ILLNESS?** Did case-patient have a respiratory illness within the 4-week period before onset of limb weakness?
27. **RESPIRATORY ILLNESS ONSET DATE.** Case-patient's respiratory onset date.
28. **GASTROINTESTINAL ILLNESS?** Did case-patient have a gastrointestinal illness (e.g., diarrhea or vomiting) within the 4-week period before onset of limb weakness?
29. **GASTROINTESTINAL ILLNESS ONSET DATE.** Case-patient's gastrointestinal illness onset date.
30. **RASH?** Did case-patient have a new onset rash within the 4-week period before onset of limb weakness?
31. **RASH ONSET DATE.** Case-patient's rash onset date.
32. **FEVER?** Did case-patient have a fever (≥38°C/100.4°F), measured by parent or provider, within the 4-week period before onset of limb weakness?
33. **FEVER ONSET DATE.** Case-patient's fever onset date.
34. **IMMUNOSUPPRESSING AGENTS?** Did case-patient receive any immuno-suppressing agents within the 4-week period before onset of limb weakness?
35. **IF YES, LIST.** If any, list the date medication first administered, name of medication, how administered, and the dosage, duration, and overall amount received by case-patient.
36. **TRAVEL OUTSIDE U.**S.? Did case-patient travel outside the U.S. within the 4-week period before onset of limb weakness?
37. **IF YES, LIST.** If any, list the country(s) visited by the case-patient.
38. **UNDERLYING ILLNESSES?** Does the case-patient have any underlying illnesses?
39. **IF YES, LIST.** List the case-patient's underlying illness(es).
40. **FEVER ON DAY OF LIMB WEAKNESS ONSET?** Did the case-patient experience a fever (see definition in 32.) on the day of onset of limb(s) weakness?

Polio vaccination history

41. **IPV DOSES?** Indicate, if known, the number of documented inactivated polio vaccine doses received by the case-patient before the onset of limb weakness.
42. **OPV DOSES?** Indicate, if known, the number of documented oral polio vaccine doses received by the case-patient before the onset of limb weakness.
43. **DOCUMENTED POLIO VACCINE DOSES IF TYPE UNKNOWN?** If type of vaccine not known, indicate the total number of documented polio vaccine doses received by case-patient before the onset of weakness.

Neuroradiographic findings

44. **MRI OF SPINAL CORD PERFORMED?** Indicate whether case-patient had an MRI of the spinal cord performed.
45. **IF YES, NUMBER OF SPINAL MRIs PERFORMED.** If case-patient had spinal MRI performed, indicate the number of documented spinal MRIs performed.
    For questions 46-71, complete based on results from the most abnormal MRI.
46. **DATE OF STUDY.** Date of the most abnormal MRI of the case-patient's spinal cord.
47. **LEVELS IMAGED.** Indicate the spinal cord levels imaged by MRI.
48. **LOCATION OF LESIONS.** Indicate the location of spinal cord lesions.
49. **CERVICAL CORD LEVEL.** Indicate whether the cervical level was affected.
50. **THORACIC CORD LEVEL.** Indicate whether the thoracic level was affected**.**
51. **AREAS OF SPINAL CORD AFFRECTED.** For cervical and thoracic levels, indicate what spinal cord areas were affected.
52. **CORD EDEMA.** Was there cord edema?
53. **GADOLINIUM USED?** Was gadolinium used with the spinal cord MRI? *If NO, skip to question 59.*
54. **GRAY MATTER LESIONS.** For cervical/thoracic cord or conus lesions if gadolinium used, was there enhancement of any gray matter lesions?
55. **WHITE MATTER LESIONS.** For cervical/thoracic cord or conus lesions if gadolinium used, was there enhancement of any white matter lesions?
56. **CERVICAL/THORACIC NERVE ROOTS.** For cervical/thoracic cord or conus lesions if gadolinium used, was there enhancement of any cervical/thoracic nerve roots?
57. **VENTRAL NERVE ROOTS.** For cauda equina lesions if gadolinium used, was there enhancement of the ventral nerve roots?
58. **DORSAL NERVE ROOTS.** For cauda equina lesions if gadolinium used, was there enhancement of the dorsal nerve roots?
59. **BRAIN MRI PERFORMED.** Indicate whether case-patient had a brain/brainstem/cerebellum MRI performed. *If NO, skip to question 72.*
60. **DATE OF STUDY.** Date of the MRI of the case-patient's brain.
61. **SUPRATENTORIAL LESIONS.** Were there any supratentorial lesions identified with the brain MRI?
62. **IF YES, INDICATE LOCATION.** Indicate location of supratentorial lesions identified with the brain MRI.
63. **BRAINSTEM LESIONS.** Were there any brainstem lesions identified with the brain MRI?
64. **IF YES, INDICATE LOCATION.** Indicate location of brainstem lesions identified with the brain MRI.

65. **CRANIAL NERVE LESIONS.** Were there any cranial nerve lesions identified with the brain MRI?
66. **IF YES, INDICATE CRANIAL NERVES.** Indicate in which cranial nerve(s) lesions were detected with the brain MRI.
67. **CEREBELLUM LESIONS.** Were there any lesions detected in the cerebellum?
68. **GADOLINIUM USED?** Was gadolinium used with the brain MRI? *If NO, skip to question 72.*
69. **SUPRATENTORIAL LESIONS.** If gadolinium used, was there enhancement of any supratentorial lesions?
70. **BRAINSTEM LESIONS.** If gadolinium used, was there enhancement of any brainstem lesions?
71. **CRANIAL NERVE LESIONS.** If gadolinium used, was there enhancement of any cranial nerve lesions?
72. **EMG DONE?** Indicate if an EMG was performed and if so, indicate the date.
73. **IF YES, ACUTE MOTOR NEUROPATHY?** If yes an EMG was done, was there evidence of acute motor neuropathy, motor neuropathy, motor nerve or anterior horn cell involvement?
74. **LUMBAR PUNCTURE PERFORMED?** Indicate if there was a CSF examination done (option for up to two. If more than 2 CSF examinations performed, list the first 2 performed.
    67a. **CSF from LP1.** Complete findings for lumbar puncture 1.
    67b. **CSF from LP2.** Complete findings for lumbar puncture 1.
75. **WAS CSF TESTED?** Complete information for CSF specimen testing for any of the pathogens listed, test type, test results, whether specimen was typed, and type if known. Provide information for the EARLIEST specimen collected if more than one CSF specimen collected and tested.
76. **WAS A RESPIRATORY TRACT SPECIMEN TESTED?** Complete information for respiratory tract specimen testing for any of the pathogens listed, test type, test results, whether specimen was typed, and type if known. Provide information for the EARLIEST specimen collected if more than one respiratory specimen collected and tested.
77. **WAS A STOOL SPECIMEN TESTED?** Complete information for stool specimen testing for any of the pathogens listed, test type, test results, whether specimen was typed, and type if known. Provide information for the EARLIEST specimen collected if more than one stool specimen collected and tested.
78. **WAS SERUM TESTED?** Complete information for serum specimen testing for any of the pathogens listed, test type, and test results. Provide information for the EARLIEST specimen collected if more than one serum specimen collected and tested.
79. **SPECIFIC ETIOLOGY?** Was/Is a specific etiology considered to be the most likely cause for the patient's neurological illness?
80. **IF YES, LIST.** List the etiology determined and reason(s) for considering it the most likely cause for the case-patient's neurological illness.
81. **SPECIMENS TO CDC.** If case-patient classified as confirmed or probable, will clinical specimens be sent to CDC for testing?
82. **SPECIMEN TYPES TO CDC.** If yes, indicate the specimen type(s) that will be sent to CDC.

Case Definition

In June 2015, the Council of State and Territorial Epidemiologists (CSTE) adopted a standardized case definition for acute flaccid myelitis[6 pages]. As of August 1, 2015, a patient must meet the CSTE clinical criteria below to be considered either a confirmed or probable case of acute flaccid myelitis:

Acute Flaccid Myelitis case definition:
(http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2015PS/2015PSFinal/15-ID-01.pdf)

Clinical Criteria

An illness with onset of acute focal limb weakness AND

- a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments, OR
- cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm^3)

Case Classification

Confirmed:

- An illness with onset of acute focal limb weakness AND
- MRI showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments

Probable:

- An illness with onset of acute focal limb weakness AND
- CSF showing pleocytosis (white blood cell count >5 cells/mm^3).

FOR LOCAL USE ONLY

Name of person completing form: _____ State assigned patient ID: _____

Affiliation_____ Phone: _____Email: _____

Name of physician who can provide additional clinical/lab information, if needed _____

Affiliation_____ Phone: _____ Email: _____

Name of main hospital that provided patient's care: _____ State: _____ County: _____

----------***DETACH and transmit only lower portion to limbweakness@cdc.gov if sending to CDC***----------

Acute Flaccid Myelitis: Patient Summary Form

Form Approved
OMB No. 0920-0009
Exp Date: 04/30/2016

Form to be completed by, or in conjunction with, a physician who provided care to the patient during the neurological illness. Once completed, submit to Health Department (HD). HD can also facilitate specimen testing.

1. Today's date__ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **2**. State assigned patient ID: _____

3. Sex: ☐ M ☐F **4.** Date of birth __ __/ __ __/ __ __ __ __ Residence: **5**. State_____ **6.** County_____

7. Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Other Pacific Islander ☐White *(check all that apply)* **8**. Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino

9. Date of onset of limb weakness __ __/__ __/__ __ __ __ *(mm/dd/yyyy)* **10**. Was patient admitted to a hospital? ☐yes ☐no ☐unknown

11. Date of admission to **first** hospital__ __/__ __/__ __ __ __ **12.**Date of discharge from **last** hospital__ __/__ __/__ __ __ __(or ☐ still hospitalized at time of form submission)

13. Did the patient die from this illness? ☐yes ☐no ☐unknown **14**. If yes, date of death__ __/__ __/__ __ __

SIGNS/SYMPTOMS/CONDITION:				
	Right Arm	Left Arm	Right Leg	Left Leg
15. Since neurologic illness onset, which limbs have been acutely weak? [*indicate yes(y), no (n), unknown (u)* ***for each limb***]	Y N U	Y N U	Y N U	Y N U
16. Date of neurologic exam (recorded at most severe weakness to point of completing this form) *(mm/dd/yyyy)*	__ __/__ __/__ __ __ __			
17. At the time of most severe weakness, reflexes in the **most affected** limb(s):	☐ Areflexic/hyporeflexic (0-1) ☐ Normal (2) ☐ Hyperreflexic (3-4+)			
At ANY time during the illness, was there:				
18. Any sensory loss/numbness in the **affected** limb(s), at any time during the illness? (paresthesias should not be considered here)	Y N U			
19. Any pain or burning in the **affected** limb(s)?	Y N U			

	Yes	No	Unk/Not Recorded (NR)
20. Sensory level on the torso (i.e., reduced sensation below a certain level of the torso)?			
21. Did patient have any of the cranial nerve features below? (If yes, check all that apply):			
☐Diplopia/double vision (If yes, circle the cranial nerve involved if known: 3 / 4 / 6)			
☐Loss of sensation in face ☐ Facial droop ☐Hearing loss ☐ Dysphagia ☐ Dysarthria			
22. Bowel or bladder incontinence?			
23. Change in mental status (e.g., confused, disoriented, encephalopathic)?			
24. Seizure(s)?			
25. Receipt of positive pressure ventilation, including invasive or non-invasive ventilation and including BiPAP or CPAP?			

Other patient information:

In the 4-weeks **BEFORE onset** of **limb weakness**, did patient:	Yes	No	Unk/NR	
26. Have a respiratory illness?				**27**. If yes, onset date __ __/__ __/__ __ __ __
28. Have a gastrointestinal illness (e.g., diarrhea or vomiting)?				29. If yes, onset date __ __/__ __/ __ __ __ __
30. Have a new onset rash?				31. If yes, onset date __ __/__ __/__ __ __ __
32. Have a fever, measured by parent or provider and ≥ 38.0°C/100.4°F?				**33**. If yes, onset date __ __/__ __/__ __ __ __

34. Receive any immunosuppressing agent(s) (BEFORE WEAKNESS ONSET)?				Form Approved OMB No. 0920-0009 Exp Date: 04/30/2016 **35.** If yes: Date of first administration: __ __/ __ __ / __ __ __ __ Name of medication: _____ Mode of administration: ☐IM ☐IV ☐Oral Dosage / duration / overall amount administered: _____
36. Travel outside the US?				**37.** If yes, list country:
38. At onset of limb weakness, does patient have any underlying illnesses?				**39.** If yes, list:
40. On the day of onset of limb weakness, did patient have a fever?				(see definition for fever above in 32.)

Polio vaccination history:	
41. How many doses of **inactivated polio vaccine (IPV**) are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
42. How many doses of **oral polio vaccine (OPV)** are **documented** to have been received by the patient before the onset of weakness?	_____doses ☐unknown
43. If you do not have documentation of the *type* of polio vaccine received what is total number of **documented** polio vaccine doses received before onset of weakness?	_____doses ☐unknown

Neuroradiographic findings:

MRI of spinal cord **44.** Was MRI of spinal cord performed? ☐ yes ☐no ☐ unknown

45. If yes, how many documented spinal MRIs were performed? _____

*If yes to Q44, complete Q46-Q71 based on **most abnormal spine MRI*** **46.** Date of most abnormal spine MRI __ __/__ __/__ __ __ __

47. Levels imaged: ☐cervical ☐thoracic ☐lumbosacral ☐unknown

48. Location of lesions:	☐cervical cord ☐thoracic cord ☐conus ☐cauda equina ☐unknown	Levels of cord affected (if applicable): **49**. Cervical: _____ **50.** Thoracic: _____
For **cervical and thoracic cord** lesions	**51.** What areas of spinal cord were affected?	☐predominantly gray matter ☐predominantly white matter ☐both equally affected ☐ unknown
	52. Was there cord edema?	☐ yes ☐no ☐ unknown
53. Gadolinium (GAD) used: ☐yes ☐no ☐ unknown		***(If NO, skip to question 59)***
For **cervical, thoracic cord or conus** lesions	**54**. Did any **gray** matter lesions enhance with GAD?	☐ yes ☐ no ☐ unknown
	55. Did any **white** matter lesions enhance with GAD?	☐ yes ☐ no ☐ unknown
	56. Did any cervical / thoracic nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown
For **cauda equina** lesions	**57**. Did the **ventra**l nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown

	58. Did the **dorsal** nerve roots enhance with GAD?	☐ yes ☐ no ☐ unknown

MRI of brain

59. Was brain/brainstem/cerebellum MRI performed? ☐ yes ☐no ☐ unknown (*If NO, skip to Q72*) **60.** Date of study __ __/__ __/__ __ __ __

61. Any **supratentorial** (i.e, lobe, cortical, subcortical, basal ganglia, or thalamic) lesions	☐ yes ☐ no ☐ unknown	
	62.If yes, indicate location(s)	☐cortex ☐basal ganglia ☐thalamus ☐ subcortex ☐unknown ☐Other (specify): _____
63. Any **brainstem** lesions?	☐ yes ☐ no ☐ unknown	
	64. If yes, indicate location:	☐midbrain ☐pons ☐medulla ☐unknown
65. Any **cranial nerve** lesions?	☐ yes ☐ no ☐ unknown	
	66. If yes, indicate which CN(s):	CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
		CN_____ ☐unilateral ☐bilateral CN_____ ☐unilateral ☐bilateral
67. Any lesions affecting the **cerebellum**?	☐ yes ☐ no ☐ unknown	
68. Gadolinium (GAD) used: ☐ yes ☐ no ☐ unknown	***(If NO, skip to question 72)***	
69. Did any supratentorial lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	
70. Did any brainstem lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	
71. Did any cranial nerve lesions enhance with GAD?	☐ yes ☐ no ☐ unknown	

72. Was an EMG done? ☐ yes ☐ no ☐ unknown If yes, date __ __/__ __/__ __ __ __ *(mm/dd/yyyy)*

73. If yes, was there evidence of acute motor neuropathy, motor neuronopathy, motor nerve or anterior horn cell involvement? ☐ yes ☐ no ☐ unk

CSF examination: **74**. Was a lumbar puncture performed? ☐ yes ☐ no ☐ unknown

If yes, complete 74 (a,b) (*If more than 2 CSF examinations, list the first 2 performed)*

	Date of lumbar puncture	WBC/mm3	% neutrophils	% lymphocytes	% monocytes	% eosinophils	RBC/mm3	Glucose mg/dl	Protein mg/dl
74a. CSF from LP1									
74b. CSF from LP2									

Pathogen testing performed:

75. **Was CSF tested?** ☐ yes ☐ no ☐ unknown **Specimen Collection Date __ __ / __ __/ __ __ __ __**

If 'yes', was specimen tested for the following:

	Test Type	**Test Result**	**Typed (if positive)?**	**Type**
Enterovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
West Nile Virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
West Nile Virus ☐ yes ☐ no ☐ unknown	IgM	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown		
Herpes simplex virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Cytomegalovirus ☐ yes ☐no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Varicella zoster virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Was other pathogen identified: ☐ yes ☐ no ☐ unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

76. Was a RESPIRATORY TRACT specimen tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
Type of specimen: ☐ nasopharyngeal swab ☐ nasal wash/aspirate ☐ oropharyngeal swab ☐ other, specify: _____
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
Enterovirus/rhinovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Adenovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Influenza virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

77. Was a STOOL specimen tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
Non-polio Enterovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending	☐ yes ☐ no ☐ not done	_____
Poliovirus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
Poliovirus ☐ yes ☐ no ☐ unknown	Culture	☐ Positive ☐ Negative ☐ Pending		
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

78. Was SERUM tested? ☐ yes ☐ no ☐ unknown **Specimen Collection Date** __ __ / __ __/ __ __ __ __
If 'yes', was specimen tested for the following:

	Test Type	Test Result	Typed (if positive)?	Type
West Nile Virus ☐ yes ☐ no ☐ unknown	PCR	☐ Positive ☐ Negative ☐ Pending		
West Nile Virus ☐ yes ☐ no ☐ unknown	IgM	☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending ☐ Unknown		
Was other pathogen identified: ☐ yes ☐ no unknown	If positive for other pathogen, specify test type: _____	List other pathogen(s) identified:		

79. Was/Is a **specific etiology** considered to be the most likely cause for the patient's neurological illness? ☐ yes ☐ no ☐ unknown
80. **If yes**, please list etiology and reason(s) considered most likely cause _____
_____

81. If patient is a confirmed or probable case, will specimens be sent to CDC for testing? ☐ yes ☐ no ☐ unknown
82. If yes, types of specimens that will be sent to CDC for testing:
☐ CSF ☐ Nasal wash/aspirate ☐BAL spec ☐Tracheal aspirate ☐NP/OP swab ☐Stool ☐Serum ☐ Other, list _____

Acute Flaccid Myelitis case definition

(http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/2015PS/2015PSFinal/15-ID-01.pdf)

Criteria

An illness with onset of acute focal limb weakness AND

- a magnetic resonance image (MRI) showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments, OR
- cerebrospinal fluid (CSF) with pleocytosis (white blood cell count >5 cells/mm^3)

Case Classification

Confirmed:

- An illness with onset of acute focal limb weakness AND
- MRI showing spinal cord lesion largely restricted to gray matter and spanning one or more spinal segments

Probable:

- An illness with onset of acute focal limb weakness AND
- CSF showing pleocytosis (white blood cell count >5 cells/mm^3).